

Palliative Care + Health Care Reform

....Connecting the Dots....

Diane E. Meier, MD

Director,

Center to Advance Palliative Care

Professor, Department of Geriatrics and Palliative Medicine

Mount Sinai School of Medicine

www.capc.org

www.getpalliativecare.org

diane.meier@mssm.edu



Objectives

1. What's wrong with the U.S health care system?
2. How can it be fixed?
3. What are the relevant provisions of the Accountable Care Act of 2010 for palliative care?
4. *“Be at the table or be on the menu.”* What can we promise and how can we deliver on it?

Health care in the U.S. (aka the Wild West)

- What are the ends of medicine?
 - What should they be?
 - What are they in the U.S.?
- “To cure sometimes, relieve often, comfort always.”
- The problem: “The nature of our healthcare system- specifically *its reliance on unregulated fee-for-service and specialty care*- ...explains both increased spending and deterioration in survival.”
Muenning PA, Glied SA. What changes in survival rates tell us about U.S. health care. Health Affairs 2010;11:1-9.

The Value Equation-1

$$\text{Value} = \frac{\text{Quality}}{\text{Cost}}$$

Numerator problems

- 100,000 deaths/year from medical errors
- Millions harmed by overuse, underuse, and misuse
- Fragmentation
- EBM <50% of the time
- 50 million Americans (1/8th) without access
- U.S. ranks 40th in quality worldwide

The Value Equation- 2

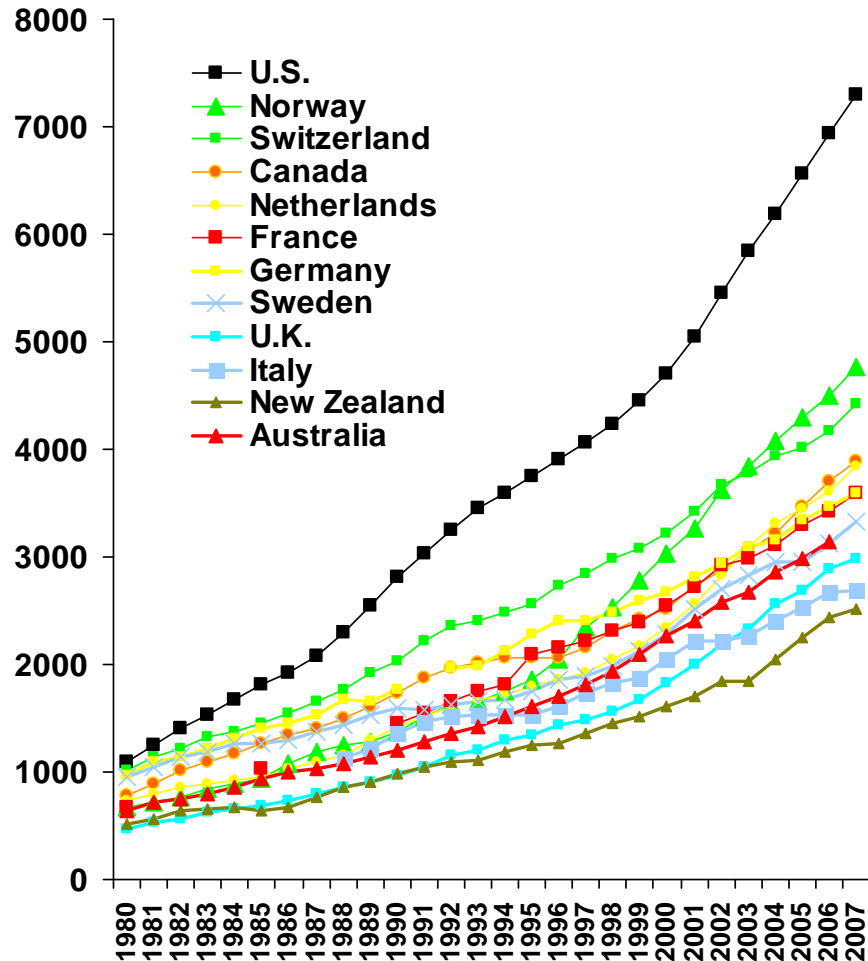
$$\text{Value} = \frac{\text{quality}}{\text{cost}}$$

Denominator problems

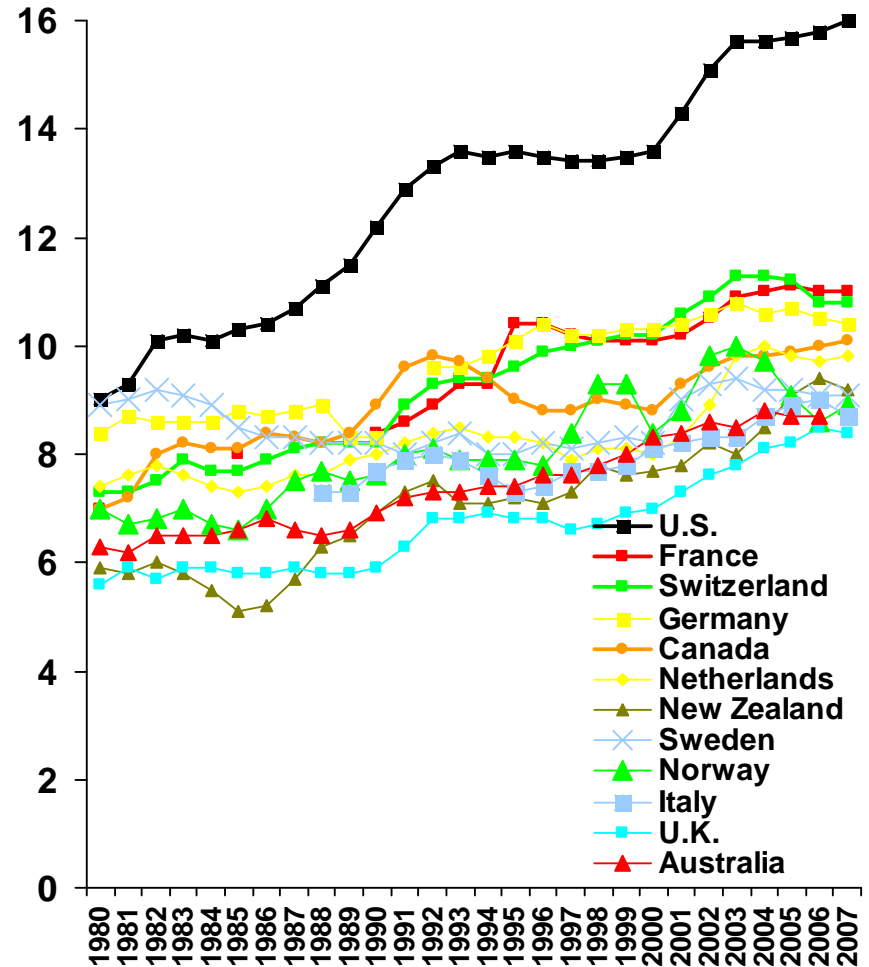
- Insurance premiums increased by 131% in the last 10 years.
- U.S. spending 18% GDP, >\$7,000 per capita/yr
- Nearing 50% of total State spending
- Despite high spending, 15% uninsured and 50% underinsured in any given year.
- Lack of health coverage contributes to at least 45,000 preventable deaths/year.
- Health care spending is the primary threat to the American economy and way of life.

Cost: International Spending on Health, 1980–2007

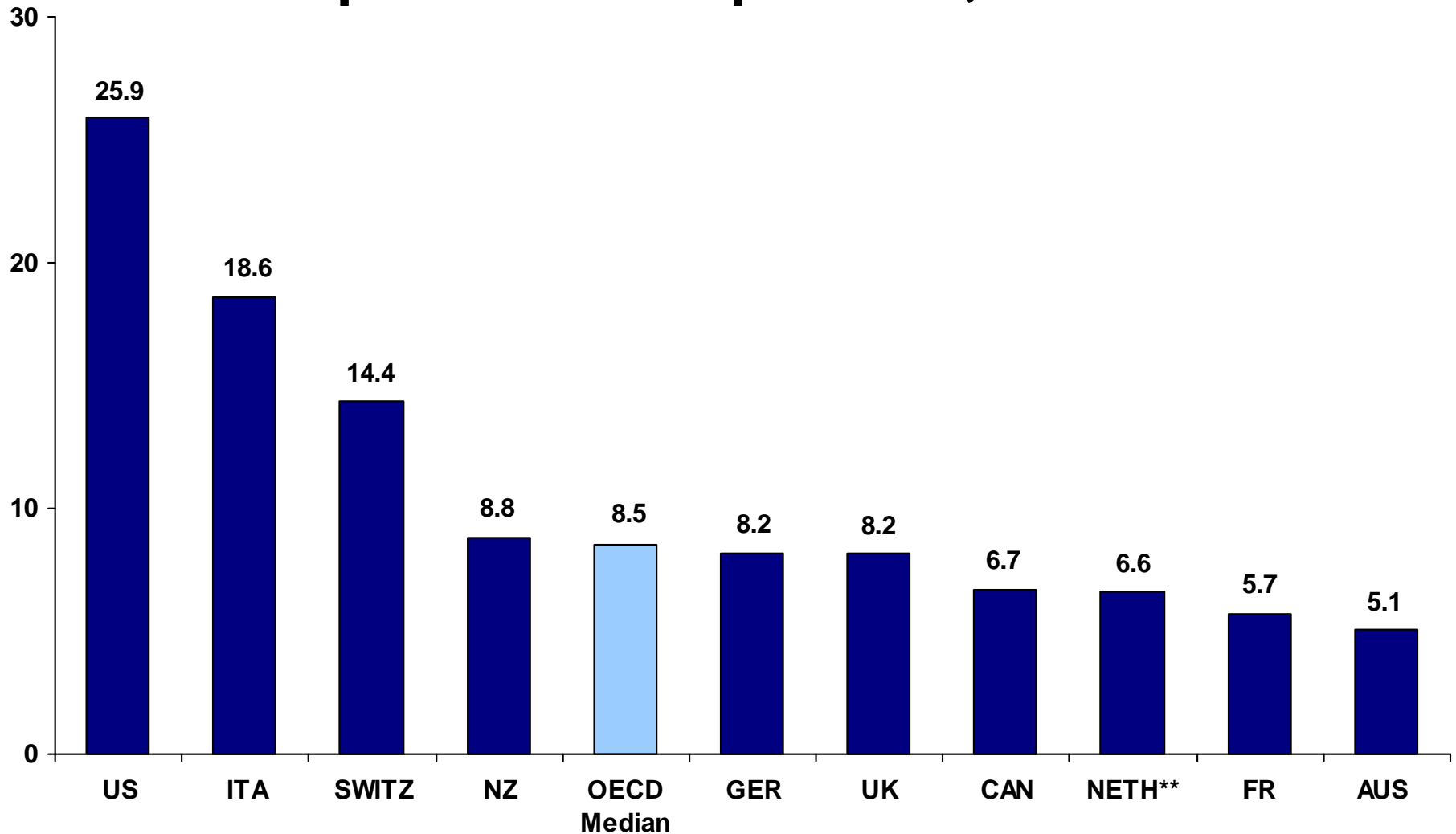
Average spending on health
per capita (\$US PPP)



Total expenditures on health
as percent of GDP



Cost and Capacity: MRI Machines per Million Population, 2007



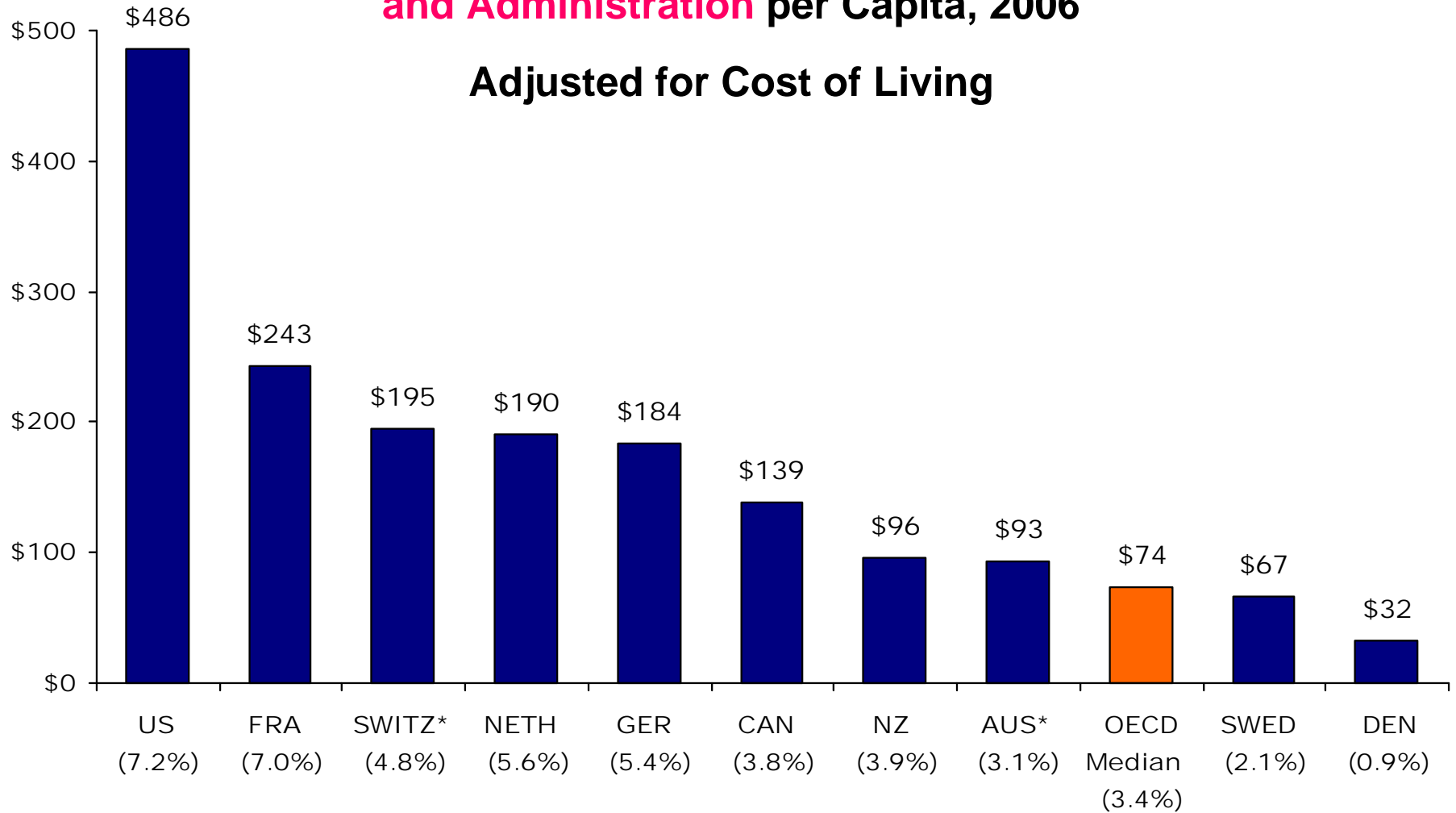
** 2005

Source: OECD Health Data 2009 (June 2009).

Cost: Where Does the Money Go?

Total Health Care **Spending on Health Insurance
and Administration** per Capita, 2006

Adjusted for Cost of Living



(Percent of total health expenditure)

*2005

Note: Total health care spending on health insurance administration includes insurer costs only.

Data: Organization for Economic Cooperation + Development- Health Data 2008 (June 2008).

What is this money buying us?

Organization for Economic Cooperation and Development

Among OECD member nations, the United States has the:

- Lowest life expectancy at birth.
- Highest mortality amenable to health care.



"It is thornlike in appearance, but I need to order a battery of tests."

U.S. Health Care Policy's “Original Sin”

*“Providers and patients still largely determine what care is needed without a **budgetary framework to consider both benefit and costs**. This is the original sin of U.S. health policy and no reform can be adequate without addressing it.”* Steurle and Bovbjerg Health Affairs 2008;27:633-44.

What can be done?

Two options to “bend the cost curve.”

1. **Stop paying** for things that add little or no quality— i.e. don’t help patients at all or enough
 - Determine best yield per dollar via Comparative Effectiveness Research
2. **Capitation** or versions thereof- i.e. set a limit on what we will spend.
 - Accountable care, bundled payments, medical homes, global budgets (eg VA, Kaiser)

Option 1: Paying for Value via Comparative Effectiveness Research

- Requires scientific comparison and willingness to implement the findings
- Means someone loses money
- Political football, labelled “rationing” and “death panels.”
- Death panel caricatures have made this topic politically untouchable.
- *“American political discourse is not yet mature enough to support realistic discussion about difficult subjects.”*

Wachter RM. JHM 2010;5:197-199.

Option 2: Setting Limits

Putting our health care system on a budget:

- HMOs in 1990's reduced spending
- Modern “integrated systems” such as VA, Kaiser, Geisinger, Mayo, Cleveland Clinics also get more quality per health care dollar
- Characteristics of success: large delivery system, advanced IT, strong primary care infrastructure, and tight integration between physicians and the organizations.



"Because of your age, I'm going to recommend doing nothing."

Spelling List

(with thanks to Bob Wachter)

- Value Based Purchasing (VBP), see also pay-for-performance (P4P)
- “Bending the cost curve”
- Comparative effectiveness research (CER), see also NICE (Nat’l Institute for Health and Clinical Excellence)
- Dartmouth Atlas, see also McAllen, Texas
- Death panels, see also rationing, socialism
- Bundled payments, see also capitation
- Medical homes, see also capitation
- Accountable care organizations, see also HMOs, capitation

Patient Protection and *Affordable Care Act (ACA)*

Patient Protection and Affordable Care Act "ACA"
(Public Law 111-148) signed into law March 23,
2010

Legislation more than 2000 pages; most sweeping
health care bill since Medicare and Medicaid
established

- Costs about \$1 trillion over 10 years
- Expands coverage to nearly 32 million of 50 million uninsured Americans.
- Cost offset by \$438 billion in new revenues and \$500 billion in spending reductions, *a large part from Medicare Advantage.*
- May reduce federal deficit by about \$28 billion over 10 years.

Main Provisions

The ACA includes:

1. Creation of new insurance marketplace through formation of state-based exchanges
2. Sweeping insurance market reforms
3. Significant changes to Medicare
4. Demonstrations and pilots to lay groundwork for fundamental delivery/payment reforms
5. Incentives for primary care, including geriatrics
6. Expansion of Health Care Workforce programs
7. Expansion of Medicaid
8. Prevention and wellness, care coordination, comparative effectiveness, quality, health IT, fraud and abuse, and elder justice initiatives



ACA Experimentation and the Value Equation

Affordable Care Act tests expansion of new delivery and payment models. All aim to improve the value equation by *setting limits on spending through versions of capitation and global budgeting.*

1. Patient Centered Medical Homes (aka Health Homes, Advanced Primary Care)
2. Bundled payment for an episode of care
3. Accountable Care Organizations

Exhibit ES-1. Organization and Payment Methods



ACA Experimentation and the Value Equation-2

The ACA also tries to improve the value equation by improving quality:

- By investing in comparative effectiveness research so we get the most out of a dollar spent;
- By markedly increasing attention to the assessment and reward for quality of care via Value Based Purchasing/Pay for Performance

Care Coordination Initiatives

Independence at Home

- Chronic care coordination pilot for Medicare beneficiaries at home

Community-Based Care Transitions

- Pilot program for hospitals and community based organizations to provide care transition services

Medicaid Health Homes

- New state option to enroll in “Health Home”

Coordination for Dual Eligible Beneficiaries

- Establishes federal office to better coordinate benefits

Payment for Quality

10% Primary Care Bonus Payment

- Begins January 1, 2011; includes geriatrics

Accountable Care Organizations

- Opportunities to share in cost-savings

Payment Bundling

- Pilot program to test a bundled payment model

Independent Payment Advisory Board

- Proposals to slow growth and improve care under Medicare

National Strategy to Improve Quality

- Plan to improve delivery, outcomes, population health

Innovation & Research

Patient-Centered Outcomes Research Institute

- Non-profit board that will identify research priorities and conduct comparative effectiveness research.

Center for Medicare and Medicaid Innovation

- Purpose is to test, evaluate and expand different Medicare and Medicaid models to improve patient care and slow cost growth.
- \$10 billion over 10 years, already appropriated

New Models

Relevance to Palliative Care

Accountable Care Organizations: ACOs are groups of providers receiving set fees to deliver *coordinated quality* care to a select group of patients.

Sec. 3022 of the ACA (Medicare Shared Savings Program) allows providers organized as ACOs that voluntarily meet quality thresholds to ***share in the cost savings*** they achieve for the Medicare program.

To qualify as an ACO, organizations must agree to be ***fully accountable for the overall care of their Medicare beneficiaries***, have adequate participation of primary care and specialist physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care.

Who can be an ACO?

Combinations of hospitals, primary care physicians, and subspecialists

Models can include

- Integrated health delivery systems
- Physician-hospital organizations (PHO)
- Hospital plus multispecialty groups
- Hospital plus independent practices
- Leader/initiator controls the cash

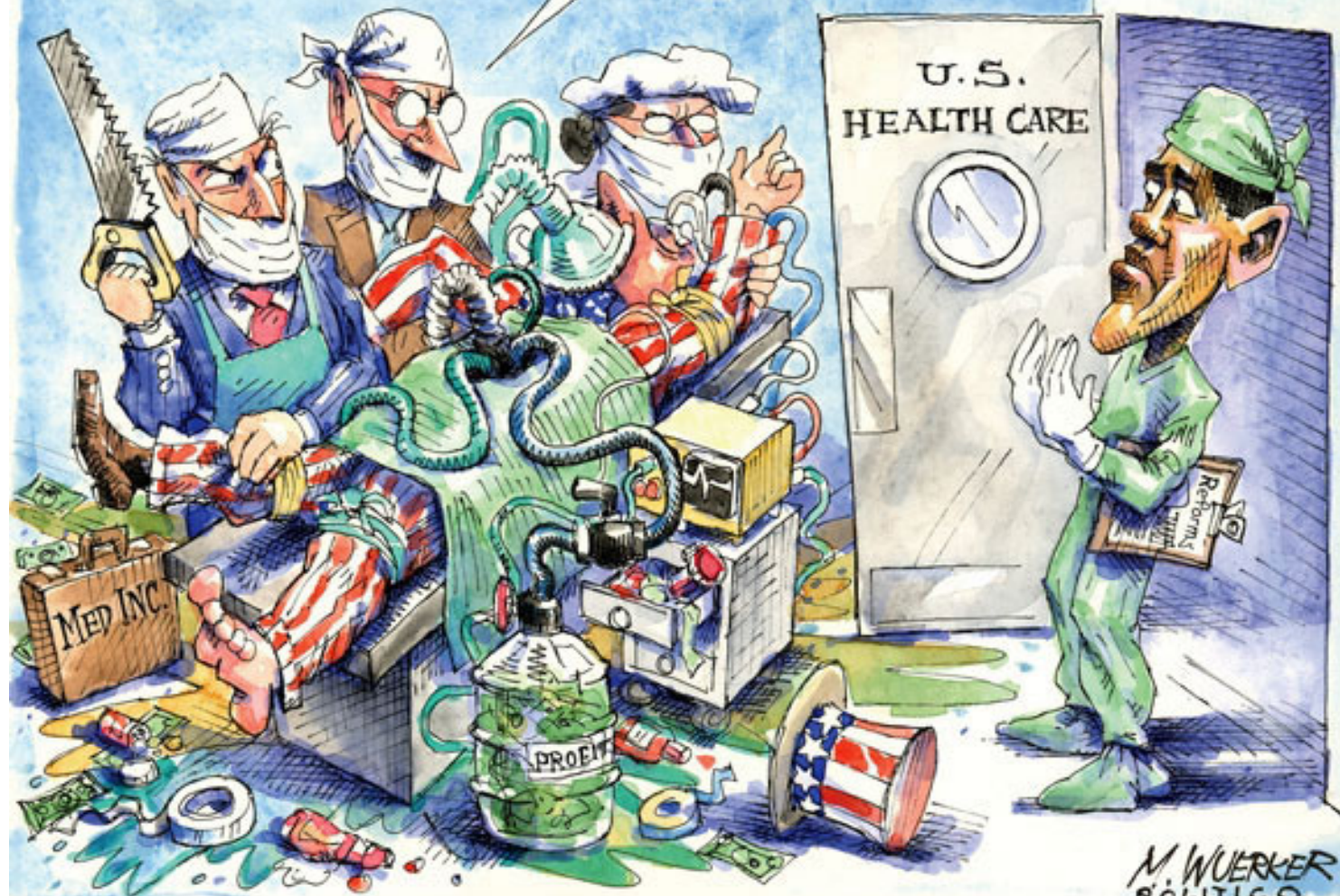
What does an ACO need to do?

- Manage quality outcomes and *overall cost for a defined population*, across a 'continuum of care'
- Prospectively plan and administer budgets, organize resources, and distribute payments
- Be responsible for comprehensive, valid and reliable performance measures for at least 5,000 Medicare beneficiaries

ACOs: No easy task...

- Historic lack of collegiality between hospitals and physicians
- The need for strong leadership to address the cultural, legal, regulatory, and resource barriers to creating new organizations
- Ensuring a strong primary care base with adequate infrastructure and resources to be accountable for a full scope of responsibilities
- Governance and joint accountability
- Determining how to distribute revenue and "shared savings"
- Cultural and workflow shifts necessary to implement efficient and high-quality models of care delivery
- Holding physicians accountable for productivity, quality and efficiency
- Implementation of necessary infrastructure, especially IT, in a capital constrained environment

REFORM? NO WAY. YOU COULD MAKE A REAL MESS OF THINGS.



New Models

Bundled Payments

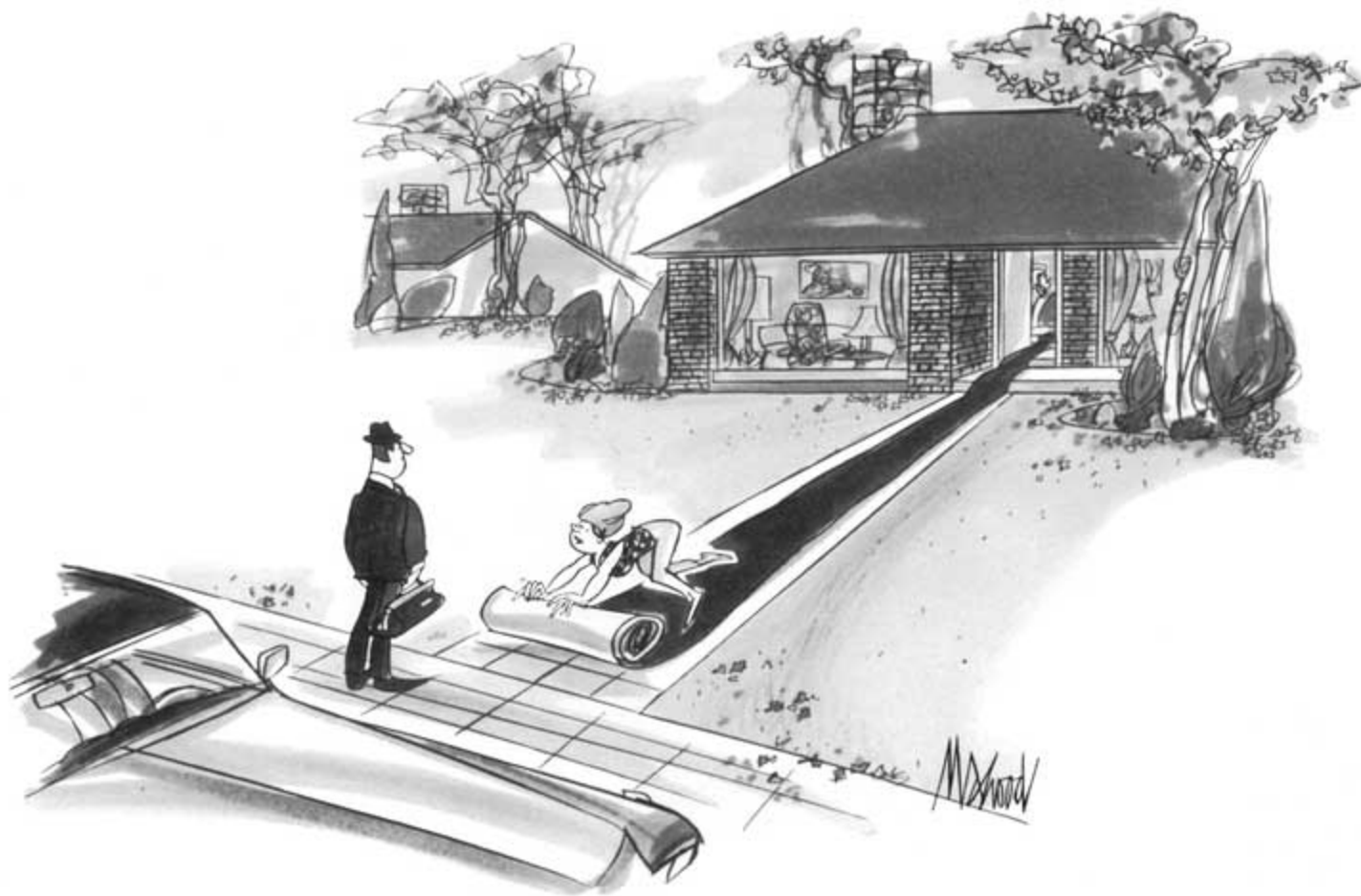
Provisions for both Medicare and Medicaid beneficiaries establish pilots to develop and evaluate paying a **single bundled payment for all services** -acute inpatient hospital, physician, outpatient, and post-acute care- for an episode of care that begins three days prior to a hospitalization and spans 30 days following discharge. If the pilot program achieves stated goals of improving or not reducing quality and reducing spending, a plan is to be developed for its expansion. Already started for hemodialysis.

New Models: Relevance to Palliative Care

Medical Homes: defined as "an approach to providing comprehensive primary care that facilitates partnerships between individual patients and their personal providers and when appropriate, the patient's family."

The CMS Medicare demonstration provides a ***care management fee to physician practices serving "high need" patients***, who must use health assessment, integrated care plans, tracking of tests and providers, review of all medications, and tracking of referrals (Tier 1), and should develop an EHR, coordinate care across settings, and employ performance metrics and reporting (Tier 2).

Per member per month payment, with or without FFS.

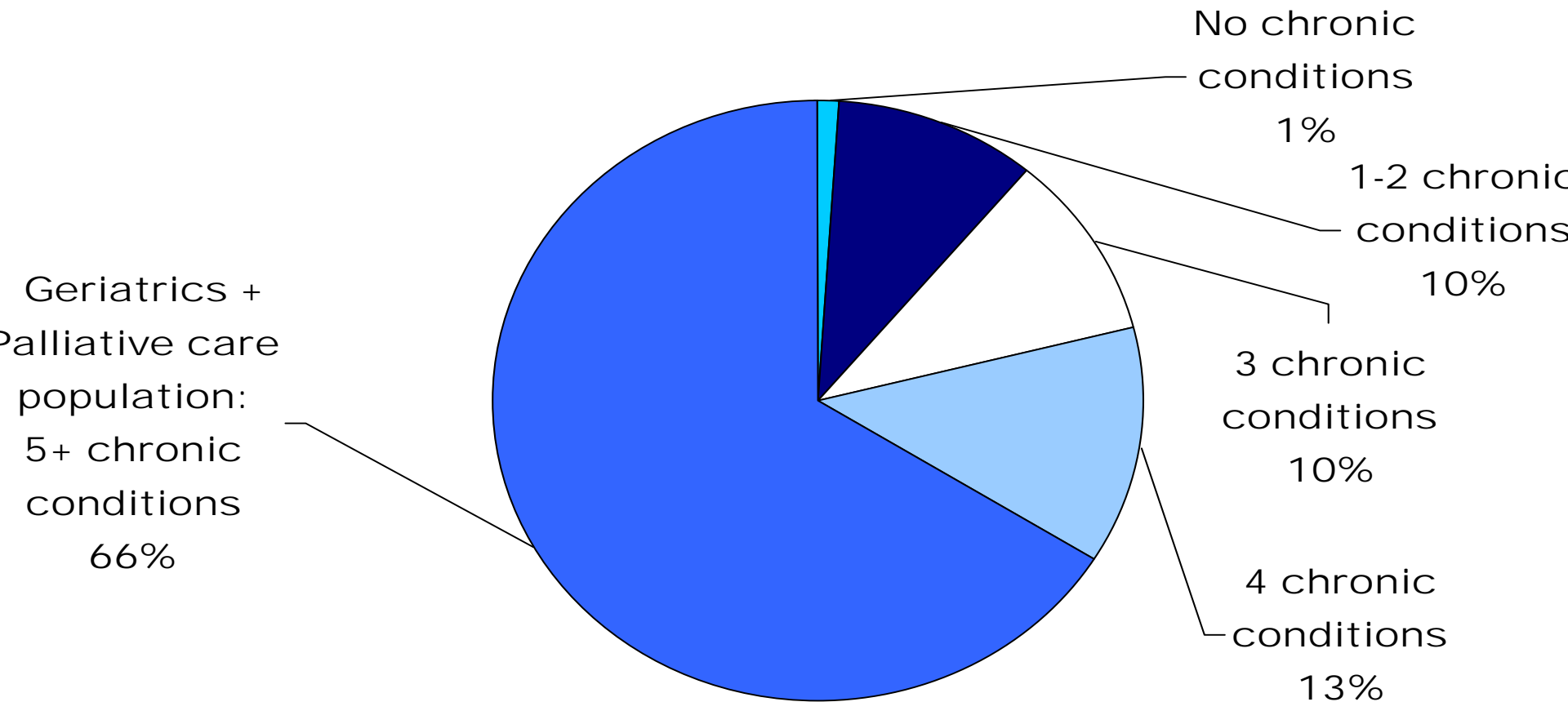


"It was good of you to come, Doctor."

Why is Palliative Care Important to Health Care Reform?

- >95% of all health care spending is for the chronically ill
- 64% of all Medicare spending goes to the 10% of beneficiaries with 5 or more chronic conditions
- Despite high spending, evidence of poor quality of care

The 10% of Medicare Beneficiaries Driving 2/3rds of Medicare Spending are Those with ≥ 5 Chronic Conditions



An Example: Grand Junction Colorado's Value Equation

Paying for Quality and Setting Limits

High quality, low cost care despite high-risk patient population.

Seven critical success factors:

1. Primary care docs in control
2. Pay for quality not quantity via shared savings
3. All-payer rate standardization
4. Regionalization of costly services
5. Limits on supply/capacity for costly services
6. Primary docs follow patients in hospital
7. **Well integrated palliative care**

New Delivery and Payment Models Need Palliative Care

Delivery models targeted to the highest-cost, highest-risk populations-- those with multiple chronic conditions and functional impairment-- will be key to success at improving quality and reducing cost.

Who else has the training and skills?

Who else has already demonstrated quality and cost impact for this population?

Policy Goal: Add geriatrics + palliative care to the eligibility/specifications/metrics for medical homes, accountable care organizations, and bundling strategies.

Why is Health Policy Reform Important for Palliative Care?

Policy Change: Why Do We Need It?

Workforce

- No GME dollars for fellowship training in palliative medicine
- No loan forgiveness for professionals training in the field
- Inadequate career development incentives for junior faculty in medical and other health professional schools (GACA, K-awards)
- Inadequate compensation for distinct effort/skill of palliative care practitioners

Evidence

- Inadequate NIH/AHRQ/VA investment in the evidence base

Access

- Inadequate financial incentives for hospitals, nursing homes, providers to deliver palliative care
- No regulatory requirements for palliative care services
- Threats to Medicare Hospice Benefit

Policies to Improve Access

1. **Financial incentives to doctors + nurses** to train in and provide palliative care: example UK payment schema for primary care
2. **Financial incentives to hospitals/NHs** that provide specialized palliative care (and penalties for those that don't). Example-preferred provider status criteria.
3. **Hospital/NH accreditation** requirements

Policies to Improve Quality

1. **Standardization, metrics:** Palliative care programs meeting quality standards are a required condition of preferred provider status/accreditation/participation/payment.
2. **Workforce is trained:** Faculty to teach workforce exist; loan forgiveness; CDAs; GME funding for palliative medicine fellowships.
3. **Evidence exists:** NIH, AHRQ + VA fund health services research in palliative care.

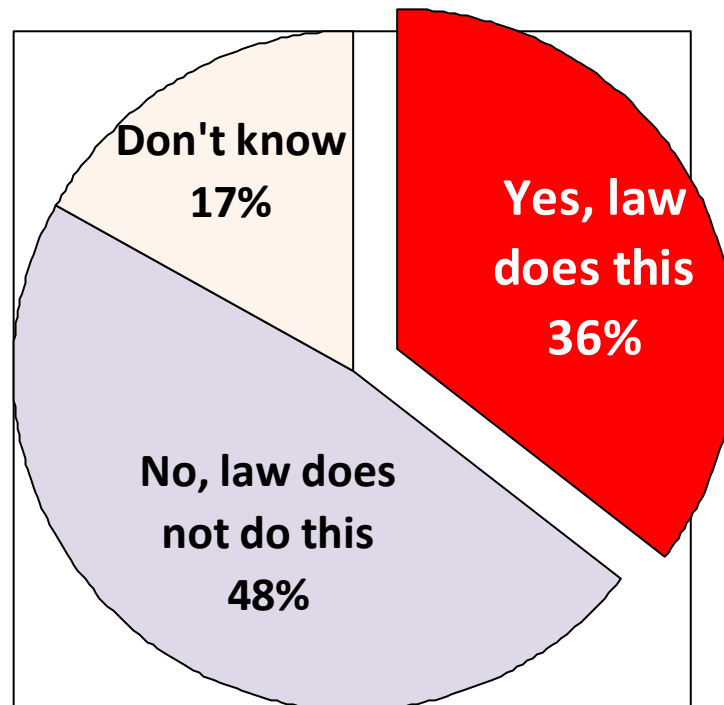
Palliative Care is in the Sweet Spot

- Improved quality
- Longer life
- Reduced costs
- So why aren't we on everybody's dance card?

Optics in Washington:

> 1/3 of all seniors say new health law includes a government panel to make end-of-life care decisions

To the best of your knowledge, would you say the new law does or does not allow a government panel to make decisions about end-of-life care for people on Medicare?



NOTE: Percentages do not sum to 100 percent due to rounding.
SOURCE: Kaiser Family Foundation *Health Tracking Polls*, July 2010.

Research to the Rescue! The Counter Message Palliative Care and Hospice PROLONG Life

New England Journal of Medicine, August 18, 2010

419,193,994 impressions

**Helping cancer patients live better,
longer**

Cancer strategy: Easing the burden

Boston Globe (8/19/10)

NBC Nightly News (9/10/10)

Palliative care can help cancer patients live longer

USA Today (8/18/10)

Palliative Care Extends Life, Study Finds

The New York Times (8/18/10)

Study shows value of quality-of-life cancer care

The Washington Post (8/18/10)

New Studies in Palliative Care

National Public Radio, *The Diane Rehm Show (8/24/10)*

Study: Advanced Cancer Patients Receiving Early Palliative Care Lived Longer

The Wall Street Journal (8/18/10)

Clarity and Consistency of Language

Palliative care is about matching treatment to patient goals.

Palliative Care Across the Continuum: How They Do It

- Full service clinics (Bluegrass)
- Health systems (Fairview, Kaiser)
- Community based, often hospice, providers (Four Seasons, Providence)
- Physician/nurse practitioner home visit programs (Kokua Kalihi Valley, VA HBPC)
- Insurers supporting enhanced case management and concurrent hospice benefits (Aetna, UHC, VNSChoice)
- GRACE, Guided Care, Hospital at Home, other proven models of care coordination for frail elderly
- See **Medicare Innovations Collaborative** for models www.med-ic.org

Influencing Policy

“Democracy is the worst form of government except all those other forms that have been tried from time to time.”

Winston Churchill Nov. 11, 1947 in a speech to the House of Commons

Importance of Grassroots Advocacy

- Politically active members help advance the legislative agenda on Capitol Hill
- Members of Congress rely on input from people like *you* to educate them on aging-related issues
- Letters, visits, and phone calls from constituents help staffers and lawmakers develop their positions, decide whether to co-sponsor a bill, and determine how they vote on a particular issue
- Lawmakers are ultimately accountable to the constituents who elect them
- The squeaky wheel gets the grease

Drivers of Policy Change

Effective lobbying by alliances of membership organizations + their members

Relationships with key Hill staff and members and (especially right now) HHS operating divisions

Unified Voice is crucial

- Hospice and Palliative Care Coalition
AAHPM, CAPC, HPNA, NASW,
NHPCO, NPCRC
- AGS, GSA, NCOA, EWA



"You can't spend your political life hiding behind being Canadian."

What you can do

Join and participate in membership organizations.

Visit AAHPM advocacy center at www.capwiz.com/aahpm

Meet with your own elected representatives.

When your organization asks you to call, email, send letters, do it.

It actually matters and makes a difference.

What you can do

If your hospital or system is working on becoming an ACO, developing a PCMH, bundled payment initiatives, or medical home visits for Multiple Chronic Conditions, reach out to the palliative care teams in your community.

Ask them to participate in planning and development.

A skeptic, persuaded

Submit public comments when asked- they are taken extremely seriously in Washington.

